

Health,  
& Welfare  
Public  
Service

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-028545

STATE FILE NUMBER

FILED AUG 25 1958

Registration District No. 41

Primary Registration District No. 3012

Registrar's No. 64

2  
300  
1-57

1. PLACE OF DEATH a. COUNTY <b>Clay</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Clay</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Excelsior Springs</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>Excelsior Springs</b> 6002
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>517 Isley Blvd.</b>		Length of stay in 1b	d. STREET ADDRESS (If outside, give location) <b>517 Isley Blvd.</b>

3. NAME OF DECEASED (Type or print) First <b>Robert</b> Middle <b>Lee</b> Last <b>Bryant</b>			4. DATE OF DEATH Month <b>July</b> Day <b>30</b> Year <b>1958</b>		
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5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3-27-1872</b>	9. AGE (In years last birthday) <b>86</b>	IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	IF UNDER 24 HRS. Hours <input type="checkbox"/> Min. <input type="checkbox"/>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farming</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Farming</b>	11. BIRTHPLACE (City and state or country) <b>Newport, Tennessee</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
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13a. FATHER'S NAME <b>Aaron Bryant</b>	13b. MOTHER'S MAIDEN NAME <b>Nancy Sisk</b>	14. NAME OF HUSBAND OR WIFE <b>Neola Bryant</b>
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>	16. SOCIAL SECURITY NO. <b>none</b>	17. INFORMANT <b>Mrs. Neola Bryant, 517 Isley Blvd. Excelsior Springs, Mo.</b>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 1/2 yrs.</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <b>hypertension</b>	<b>years</b>
	DUE TO (c) <b>arteriosclerosis</b>	<b>33 1/2 years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
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20c. TIME OF INJURY Hour <input type="checkbox"/> Month, Day, Year <input type="checkbox"/> a.m. <input type="checkbox"/> p.m. <input type="checkbox"/>	20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION <b>Excelsior Springs, Mo.</b>	COUNTY <b>Clay</b>	STATE <b>Missouri</b>
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21. I attended the deceased from <b>12/22/57</b> to <b>7/30/58</b> and last saw <b>him</b> alive on <b>7/25/58</b> Death occurred at <b>5:00 A.</b> m on the date stated above; and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE <b>Dr. M. D. Cricken</b> (Degree or title) <b>M. D.</b>	22b. ADDRESS <b>Excelsior Springs, Mo.</b>	22c. DATE SIGNED <b>8/5/58</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>8-1-1958</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Old New Garden Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>Excelsior Springs, Mo.</b>
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24. FUNERAL DIRECTOR <b>Prichard Funeral Home, Inc.</b> <b>Excelsior Springs, Missouri</b>	25. DATE RECD. BY LOCAL REG. <b>8/6/58</b>	26. REGISTRAR'S SIGNATURE <b>Caroline Hutchings</b>
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All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION



STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by ....., Student Embalmer No. .... working under my personal supervision.

Student .....  
Signature of Student Embalmer

Signed *Lindsey Jarman* .....

Licensed Embalmer No. *4589*  
P. O. Address *Enoch Springs, Mo.*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).  
If embalmed by a STUDENT, he also shall sign in his OWN handwriting. ---  
If this body is not embalmed, fact should be so stated above.